

TESTIMONY OF STEVEN BROWN

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In the United States Federal District Court for the District of Idaho
Saint Alphonsus Medical Center-Nampa, Inc., et al. v. St. Luke's Health System Ltd., et al.
Case No. 1:12-cv-00560-BLW

Page Range: 7:05:7:09

05 Q. Could you please state and spell your
06 full name for the record.
07 A. Certainly. Steven Dunning Brown,
08 S-t-e-v-e-n, middle name D-u-n-n-i-n-g, last name
09 Brown, B-r-o-w-n.

Page Range: 16:21-17:09

21 Q. And what position were you recruited
22 for?
23 A. Vice President, Chief Medical Officer,
24 and the President of Saint Alphonsus Medical
25 Group.
17:01 Q. And that's the same title you hold
02 today correct, or titles?
03 A. Correct.
04 Q. Have there been any changes in your
05 roles or responsibilities since you've been at
06 Saint Alphonsus?
07 A. I was interim President of the
08 Saint Alphonsus Health Alliance during its
09 concept, development, and early phases.

Page Range: 39-23-40:04

23 Q. Okay. With respect to -- I guess
24 backing down a little bit -- not the system level,
25 but the Saint Alphonsus Medical Group level,
40:01 anything aside from the implementation of
02 MedVentive and the patient-centered medical home
03 that the medical group has done towards clinical
04 integration?

Page Range: 40:07-40:20

07 Generally, the Saint Alphonsus Medical
08 Group has become more uniform in its organization
09 and processes, anything from information systems,
10 staffing models, so that it can achieve clinical

11 integration and efficiencies. So these are all
12 operational and process matters.
13 Q. BY MR. SCHAFER: All right. And how
14 does increasing sort of the uniformity of those
15 things aid in the goal of clinical integration?
16 A. Within a single multispecialty group
17 practice, not to be confused with the entire
18 Alliance, it lends itself to creating benchmarks
19 and being able to adjust processes to benchmarks
20 within a group.

Page Range: 43:23-44:04

23 Q. BY MR. SCHAFER: All right. Dr. Brown,
24 the court reporter has handed you Defendants'
25 Exhibit 175, which is a single-page E-mail
44:01 Bates-labeled ALPH00008415. It is an E-mail from
02 Janelle Reilly to you, Robert Polk, Blaine
03 Petersen, and Sally Jeffcoat. Do you see that?
04 A. I do.

Page Range: 46:22-47:11

22 Q. Okay. You referenced in connection to
23 an earlier question that, you know, you understand
24 that there is now a ConnectedCare product on the
25 market that involves Saint Alphonsus, correct?
47:01 A. Correct.
02 Q. Do you know whether that, the product
03 currently on the market, contains any aspect of
04 utilization reductions or gain sharing with
05 respect to utilization reductions?
06 A. I -- I don't understand that it does
07 right now.
08 Q. Okay. And how about shared savings
09 more generally? Are you aware of that product
10 containing any aspect of shared savings?
11 A. No.

Page Range: 51:12-51:18

12 Q. And Saint Alphonsus is not developed
13 in -- or has not been an ACO organization,
14 correct?
15 A. In the Medicare sense, no.
16 Q. Has it become an ACO in another sense?
17 A. No. It -- it's -- it is developing a
18 clinically integrated network.

Page Range: 51:19-51:20

19 Q. Okay. But not a Medicare ACO network?
20 A. Correct.

Page Range: 52:13-52:22

13 Q. And Saint Alphonsus obviously made the
14 decision at some point not to become an ACO
15 Medicare -- a Medicare ACO organization, correct?
16 A. Correct.
17 Q. And why was that decision made?
18 A. We made a decision not to become a
19 Medicare ACO based upon the current -- well,
20 actually, the final rules and the complexity
21 around those and felt like that that was a -- not
22 the correct direction at this time.

Page Range: 53:05-53:19

05 Q. All right. And what was it about the
06 complexity of the rules that caused Saint
07 Alphonsus to think that that wasn't the right
08 direction to go in?
09 A. As an example, the attribution
10 requirements and the quality requirements.
11 Q. What -- what about them?
12 A. Well, the attribution requirements were
13 fairly onerous and retrospective, and the quality
14 goals were, as I recall, about 60 metrics, 15 so . . .
15 Q. Are there any current plans that you're
16 aware of to become an ACO organization in the
17 future?
18 A. No. We have no current plans of
19 becoming a Medicare ACO.

Page Range: 68:16-70:12

16 Q. With respect to the reference here to
17 the "being able to easily program evidence-based
18 parameters for wellness and disease management,"
19 is that the same concept? Is that something
20 that's done through the patient registry?
21 A. Yes.
22 Q. And how is that done?
23 A. That patient -- well, what is your
24 specific question? You're saying who gets to

25 decide what those are or are you saying how do
69:01 you physically begin to program it into a
02 registry?
03 Q. Both.
04 A. Okay. Within the Saint Alphonsus
05 Health Alliance, independent and employed
06 physicians agree through the Quality Committee to
07 decide what the best practices are for those
08 diseases.
09 You asked earlier about primary care.
10 The vast majority of these goals reside at the
11 primary care office and not in the specialist's
12 office.
13 Second is that the registry is -- is
14 designed so that end users can put those
15 parameters in and create the reports, again on
16 demand, by the various providers.
17 Q. Okay. And is that something that is
18 contained within MedVentive?
19 A. Yes.
20 Q. And can -- with respect to MedVentive's
21 sitting at independent providers, does MedVentive
22 need to have a separate EHR system to interact
23 with or can it exist on its own?
24 A. As a matter of fact, it doesn't
25 actually require an EHR.
70:01 Q. So a provider can interact directly
02 with MedVentive and doesn't need any other
03 electronic system?
04 A. Well, assuming -- the requirement is
05 that they have to have an electronic billing
06 submission program of some kind, which virtually
07 all providers do, but it doesn't require a common
08 one. It doesn't require an EHR and certainly
09 doesn't require a common EHR.
10 So the goals of clinical integration
11 can be met without any EHR at all, if you will,
12 and certainly does not require a single EMR.

Page Range: 70:17-70:20

17 Q. BY MR. SCHAFER: I believe that --
18 the court reporter has handed you a document that
19 she's marked as Defendants' Exhibit 177, Bates-
20 labeled ALPH00044791 through 797.

Page Range: 71:21-72:23

21 Q. Okay. So specific sections, if you go
22 to the page that ends with 792, the back of the
23 first page.
24 A. Okay.
25 Q. The bottom paragraph there starting
72:01 "Saint Alphonsus."
02 A. Yes.
03 Q. "Saint Alphonsus desires to change the
04 rules of engagement by aggressively developing a
05 clinical population management system focused on
06 access and market differentiation."
07 To the extent that you had a role in
08 this section of the document and understand what
09 that means, what -- what did it mean to "change
10 the rules of engagement"?
11 A. The rules of engagement that they are
12 referring to is a transformation, again, from just
13 an episodic basis of care to more of a continuum
14 of care, and that rules of engagement involves
15 both providers and patients.
16 Q. And with respect to the "aggressive
17 development of a clinical population management
18 system," what -- what did that mean, the
19 aggressive development? You know, to the extent
20 you wrote that or contributed to that, do you know
21 what was meant by that?
22 A. I believe it means that an accelerated
23 development.

Page Range: 74:08-75:03

08 Q. If you skip to the top of the next page
09 ending in 793, it says, "Market competitive forces
10 in the Treasure Valley bring a sense of urgency to
11 this vision and the reality of having a CPMS."
12 What were the "market competitive
13 forces in the Treasure Valley" that brought that
14 sense of urgency?
15 A. I think the market competitive
16 forces are -- are twofold: one, the presence of
17 St. Luke's, of course; and two, is the competitive
18 forces among payers and employers.
19 Q. And why did those competitive forces
20 bring a sense of urgency to that vision?
21 A. Well, as I've explained before,
22 employers and payers are now developing an

23 expectation around the ability to achieve the
24 triple aim.
25 Q. And so that brought a sense of urgency
75:01 to Saint Al's being able to establish a system
02 that would accomplish the triple aim?
03 A. Correct.

Page Range: 85:10-85:20

10 Q. Okay. Do you remember sort of the
11 context of when you were first asked to opine on
12 any issues with respect to Saltzer?
13 A. It was introduced to me as a -- an
14 important medical group within Nampa due to its
15 long-standing nature in the community, the fact
16 that it had a significant market share, that they
17 were very important partners for our Nampa
18 hospital and related efforts, and we were looking
19 forward to them being a part of a clinically
20 integrated network.

Page Range: 86:13-87:11

13 Q. At a certain point, Saint Alphonsus
14 made a proposal to affiliate with Saltzer,
15 correct?
16 A. Well, let me be clear. Saltzer came to
17 us in that meeting and asked for a proposal for
18 affiliation.
19 Q. Okay. That -- that was my question.
20 As far as timing, whether your meeting with
21 Dr. Kaiser and Mr. Savage was before that proposal
22 was made?
23 A. Yes.
24 Q. Okay. And that proposal was made
25 in response to a request that Saltzer made to
87:01 Saint Alphonsus in that meeting?
02 A. Correct.
03 Q. What -- can you explain to me or tell
04 me, to the best you can recall, what was said
05 during that meeting?
06 A. That they wanted a proposal for the
07 various kinds of partnerships that they could
08 have with Saint Alphonsus, and as a part of their
09 diligence, that the community knew that they
10 were already developing a relationship with
11 St. Luke's.

Page Range: 87:16-87:23

16 Q. Did they tell you during that meeting
17 what their goals were in an affiliation?
18 A. Yes, they did.
19 Q. Do you remember what those goals were?
20 A. The goals, as I recall, and -- were
21 they would prefer to remain independent; they
22 weren't interested in being employed; they wanted
23 to be a part of a network.

Page Range: 87:24-88:02

24 And those were some of the preferences
25 that I recall that came out. And they -- they
88:01 wanted to be a -- a -- help with looking at health
02 reform.

Page Range: 90:22-91:11

22 Q. BY MR. SCHAFER: And what was your
23 position? You were sort of relatively new to the
24 Saint Al's system and to the area; what was your
25 position on whether or not it made sense for
91:01 Saint Al's to affiliate with Saltzer?
02 A. My great -- my greatest hope was that
03 Saltzer should remain independent. They were
04 already a successful practice. They were a
05 significant force in that medical community.
06 It is -- it is almost always better to
07 create voluntary alignment mechanisms rather than
08 to actually own or employ a physician. I know
09 that from my previous past -- or my previous
10 experiences, as well as I thought it would be best
11 for Saltzer in this case.

Page Range: 121:13-122:22

13 Q. Okay. And I guess with respect to the
14 Idaho Health Data Exchange, that is -- that
15 already exists, correct?
16 A. Correct.
17 Q. Why doesn't Saint Al's simply rely on
18 the Idaho Health Data Exchange and, you know,
19 instead spend a significant amount of money on its
20 own EMR and EHR systems?
21 A. Because Idaho Health Data Exchange
22 isn't intended to function as an electronic health

23 record. It is a repository of information.
24 Q. And what -- what is it that you can do
25 with your EHR or an EMR that you can't do through
122:01 the Idaho Health Data Exchange?
02 A. The physician order entry as -- as one
03 thing. It's -- the Idaho Health Data Exchange is
04 a repository. An EHR is more of a contemporaneous
05 document which would include interactions between
06 a wide variety of professionals in a health
07 system.
08 So you have a variety of people who are
09 charting into that, particularly on the inpatient
10 side, but that is also true on the outpatient
11 side.
12 Q. Could Saint Al's use the Idaho Health
13 Data Exchange to drive clinical integration
14 projects or initiatives?
15 A. It could be an ancillary support for
16 that, yes.
17 Q. Could it be the sole support for that?
18 A. No.
19 Q. And why is that?
20 A. Again, you need to have a -- at least a
21 patient-registry-type function that the Idaho
22 Health Data Exchange would not provide.

Page Range: 129:17-130:23

17 Q. Do you think that Saint Al's Medical
18 Group currently is a fully integrated system?
19 A. Clinically integrated system?
20 Q. Right.
21 A. Is Saint Alphonsus Medical Group? No.
22 Q. Do you have any expectations as to
23 when, putting side the Alliance, Saint Al's itself
24 will develop into a fully clinically integrated
25 system?
130:01 A. Well, perhaps you need to define for
02 me what you're calling "clinically integrated
03 system" then. I know what the elements are around
04 clinically integrated network, but you're talking
05 about a clinically integrated system, so perhaps
06 you can help me there.
07 Q. Sure. Well, I was trying to use your
08 words, so if you can define for me what you mean
09 by a "fully clinically integrated network"?
10 A. Okay. A fully clinically integrated
11 network is one that can take responsibility for a

12 continuum of care, wellness, and chronic disease
13 outcomes and reduce the overall cost of care
14 through a collaborative approach of independent
15 and employed physicians working with hospitals.
16 Q. All right. And do you – back to the
17 earlier question, do you believe Saint Al's has
18 achieved full clinical integration at this point?
19 A. No.
20 Q. Okay. And do you have an expectation
21 as to when full clinical integration may occur?
22 A. Our goal would call for that being
23 around 2014, 2015.

Page Range: 130:24-131:15

24 Q. And are there certain benchmarks
25 towards that goal that Saint Al's has established?
131:01 A. Yes, there are.
02 Q. And what are they? to the extent you
03 can tell me.
04 A. Oh, for instance, a provider network
05 agreement that a provider compacts. We've already
06 achieved some of those with a physician-led – an
07 accountable board of independent and employed
08 physicians that have come together with that
09 commitment.
10 Now it is around the part of piecing
11 together contracts and the informatics through
12 patient registries and other systems to feed back
13 to the members of the network their performance
14 within that and credentialing people into that
15 network based upon those parameters.

Page Range: 135:10-135:16

10 Q. Does Saint Alphonsus provide any
11 financial inducements or incentives to keep
12 referrals within the system?
13 A. Of course not.
14 Q. No bonus amounts tied to referrals
15 remaining in the system?
16 A. No.

Page Range: 137:20-137:24

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Page Range: 138:15-138:17

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Page Range: 138:20-139:09

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Page Range: 139:18-140:15

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Page Range: 141:14-142:05

14 Q. BY MR. SCHAFER: Is one mechanism to
15 increase the number of visits to SAMG clinics
16 to keep referrals within the system of SAMG
17 clinics?
18 A. It may not achieve that -- those
19 goals. I would -- I think of the -- it's
20 speculative.
21 Q. You think it is speculative whether
22 keeping referrals in the system will increase
23 the number of visits to providers in that system?
24 A. I think that, again, there's several
25 different mechanisms by which you can achieve
142:01 that. The intent was to make certain there was
02 access, not number of referrals.
03 So the barrier that we identified was
04 the ability to get an appointment, period, and not
05 so much an internal referral.

Page Range: 145:21-146:04

21 Q. BY MR. SCHAFER: Defendants'
22 Exhibit 185 is an E-mail with an attachment,
23 Bates-labeled ALPH00271910 through 1913. And it
24 is from Nancy Powell to a Linda Hess, copying you,
25 dated January 28th, 2013, and the attachment to it
146:01 is a document called the "SAMG Clinical
02 Integration Plan." And then underneath it is your
03 name, Steven D. Brown, M.D., correct?
04 A. Correct.

Page Range: 146:21-148:07

21 Q. Okay. And just keeping on the issue of
22 referrals, if you look down to Section 5, which is
23 "Referral to Alliance Providers." Do you see
24 that?
25 A. I do.
147:01 Q. Is that an aspect of the clinical
02 integration plan that's been adopted?
03 A. Yes. Referral to Alliance providers is
04 a -- a goal within our clinically integrated

05 network.

06 A. And are the -- "A" under "Referral" --
07 in the section -- part "A" under that says
08 "reliable and contemporaneous measurement of
09 referral patterns."

10 What does that refer to?

11 A. Within a clinically integrated network,
12 the network becomes responsible for quality and
13 utilization within that network. So it is
14 important for the Alliance to be able to measure
15 those referrals and so we can remain responsible
16 for those costs and possible incentives.

17 Q. And then it says "performance reports
18 to providers." How does that relate to referral
19 to Alliance providers?

20 A. It is actually a part of a dashboard
21 that you would want all Alliance members to have
22 around their performance, which would include
23 quality utilization and referral.

24 Q. Okay. And so is that something that's
25 been implemented with respect to the Alliance,
148:01 that their referral patterns are included in a
02 report to those providers?

03 A. Not now.

04 Q. But that's the goal?

05 A. That would be a goal when it is a fully
606 clinically integrated network, which then becomes
07 financially at risk for a population of patients.

Page Range: 148:20-149:03

20 The court reporter has now handed you a
21 version of Exhibit 179 that should have all the --
22 all the pages. And again, for the record, it's
23 document -- E-mail and attachment Bates-labeled
24 ALPH00008474 through 8503.

25 And this was an E-mail from you to

149:01 Karl Keeler, Sally Jeffcoat, Blaine Petersen, and
02 Nancy Powell, attaching a proposal for affiliation
03 with Saltzer Medical Group. Do you see that?

Page Range: 149:14-150:05

14 Q. Okay. In the first section of the
15 letter, you say "Saint Alphonsus Health System is
16 pleased to present this proposal for affiliation
17 with Saltzer Medical Group that seeks to address
18 your goals in a health system partnership," and

19 then there are six goals listed.
20 Do you see that?
21 A. I do.
22 Q. And we had discussed this morning that
23 you had had an initial meeting with the Saltzer
24 leadership, and they explained to you what their
25 goals were in affiliating with the hospital
150:01 system, correct?
02 A. Correct.
03 Q. And are these the six goals that they
04 told you?
05 A. Yes.

Page Range: 150:17-150:24

17 Q. Okay. If you go down to the bottom of
18 the -- the last sentence of that same paragraph
19 that starts "certainly," it says, "Certainly, a
20 a more formal alignment would accelerate these
21 possibilities and facilitate development of a
22 solid integrated model of healthcare delivery at
23 the Nampa campuses, throughout Canyon County, and
24 westward."

Page Range: 150:25-151:15

25 And I guess the first question is
151:01 why -- why -- why did you believe that a more
02 formal alignment would accelerate those
03 possibilities?
04 A. As I said this morning, we looked
05 forward to them being a part of the Saint
06 Alphonsus Health Alliance, realizing that there
07 were several mechanisms by which we could partner
08 with them and they would not have to be employed
09 or under a PSA agreement, but still retain --
10 achieve the six goals that are listed here.
11 And so that was a reference to a solid
12 integrated model health care delivery, clinically
13 integrated network working with them in terms of
14 recruitment. And again, it was a part of the
15 goals that you see above.

Page Range: 152:18-153:06

18 Q. In the next paragraph, starting with
19 the second sentence, you say, "Alignment with
20 SMG's geographic location, wide array of

21 specialties, and reputation for quality medicine
22 would enhance our ability to grow and develop
23 innovative programs that will benefit patients and
24 physicians."
25 Why did you believe that that alignment
153:01 Would assist with the -- the ability to grow and
02 development innovative programs?
03 A. It would allow more cooperation between
04 Saint Alphonsus with any of the proposed
05 mechanisms of partnership about achieving the same
06 goals.

Page Range: 153:07-153:18

7 Q. All right. And if you turn to page 6
8 of the proposal, this is an overview of the PSA
9 model that Saint Alphonsus was proposing to
10 Saltzer, correct?
11 A. Right.
12 Q. And if you look, this relates back to a
13 conversation we had earlier today. The first
14 sentence says, "The physician services agreement,
15 PSA, allows Saltzer Medical Group physicians to
16 remain independent yet receive income protection
17 pursuant to a professional services contract
18 between SAHS and SMG."

Page Range: 153:21-154:19

21 Q. And you, per our discussions this
22 morning, you agreed that the PSA model allow --
23 would allow the Saltzer physicians to remain
24 independent?
25 A. No. That is actually not what I said
154:01 this morning. Very specifically what I said was
02 is that there was a spectrum of independence and
03 that there were other options that would allow
04 greater independence.
05 Under this agreement, the Saltzer
06 physicians could retain a name and they would
07 also have a -- a business relationship. But, as
08 an example, had they chosen another alignment path
09 which would have made them more independent, in
10 this one, the nonphysician staff would become --
11 or I -- I -- yeah, nonphysician staff would become
12 employees of Saint Alphonsus Medical Group. They
13 would lose control of that aspect of their
14 practice under that arrangement.

15 It was a gradation of independence that
16 was provided there. So independent is -- is a
17 very qualified term in this proposal and when
18 you're talking about alignment mechanisms with
19 physicians.

Page Range: 160:14-161:11

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Page Range: 161:14-162:03

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Page Range: 162:04-162:07

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Page Range: 191:14-192:01

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Page Range: 195:07-195:14

07 Q. So just to make sure I understand. So
08 if -- if a St. Luke's employed physician and --
09 is -- does that also cover PSA affiliated
10 physicians?
11 A. To -- to be honest with you, I don't --
12 what I said was is that if they were in CAN
13 before, regardless of employed or PSA'd, they
14 would be in the Alliance now.

Page Range: 195:18-195:22

18 Q. okay. Have any St. Luke's employed or
19 PSA physicians been invited to join the Alliance
20 itself, as opposed to not rolling over from the
21 ACN?
22 A. No.

Page Range: 196:05-196:08

05 Q. Okay. And you're saying from the --
06 in the conversion of ACN to the Alliance, none of
07 those providers were weeded out?

08 A. Correct.

Page Range: 198:17-198:19

17 Q. BY MR. SCHAFER: Defendants'
18 Exhibit 189 is an E-mail from you to Tom
19 Reinhardt, Bates-labeled BDC0023651 through 652.

Page Range: 200:05-200:23

05 Q. With respect to little 4, it says,
06 "Our obligation to provide gatekeeper-like
07 referral management will be more complex and
08 potentially compromised if we include St. Luke's
09 physicians."
10 And recognizing that this may not be
11 part of formal policy, but do you agree with that
12 statement?
13 A. As we discussed earlier, in a
14 clinically integrated network where a group of
15 providers and hospitals have agreed to take, or
16 indeed go at risk, around quality and utilization
17 goals, it is -- they -- they have to be able to
18 manage that population within that network.
19 So if a patient were to have access to
20 any provider they want to, who may not be of best
21 quality or be indiscriminate in the use of
22 testing, that would injure the Alliance and -- and
23 the triple aim initiative.

Page Range: 204:22-205:02

22 Q. BY MR. SCHAFER: Defendants'
23 Exhibit 190 is Bates-labeled BDC0003371 through
24 3374, and it is an E-mail chain. The top E-mail
25 of which is from you to Mary Jo Potter, dated
205:01 June 5th, 2012. Do you see that?
02 A. I do.

Page Range: 205:11-206:25

11 Q. If you look a little bit -- three lines
12 down or so you say, "At present, Saint Alphonsus
13 does not expect Alliance members to hold exclusive
14 membership in the Alliance. However, that
15 expectation may change in the future as other
16 clinically integrated networks develop in our
17 market or situations arise that may create a

18 conflict of interest for a member in the opinion
19 of the Alliance board," correct?

20 A. Correct.

21 Q. And, you know, this was June of 2012.

22 Has that policy changed at all up to today?

23 A. No.

24 Q. And so what does it mean to not require
25 exclusive membership in the Alliance?

206:01 A. As an example, in a accountable care
02 organization, a primary care group may be only a
03 member of only one clinically integrated network,
04 and we're not making that requirement an -- excuse
05 me -- a requirement to be in an ACO.
06 And in a clinically integrated
07 network -- in particular, one reason why we didn't
08 decide to develop an ACO is to provide our
09 physicians, particularly the independent medical
10 staff, the maximum latitude to associate with --
11 in practices they -- as they wish.
12 So that means that they would have to
13 manage Alliance patients according to Alliance
14 rules and requirements around utilization and
15 quality, but does -- would not preclude them
16 necessarily from being in another network.
17 It is another strength of a clinically
18 integrated network, rather than ACO, in a
19 community like ours.
20 Q. And what is it about the -- you know,
21 you said, "That expectation may change in the
22 future as other clinically integrated networks
23 develop in our market."
24 Why -- why would you change that policy
25 if other networks developed?

Page Range: 207:02-207:12

02 THE WITNESS: Because the requirements of
03 those networks also may require exclusivity, and
04 there may be a competitive reason to start
05 including -- requiring exclusivity in those
06 circumstances.

07 Also, it -- it doesn't -- I don't want
08 to preclude the possibility that the Alliance in
09 the future may become an accountable care
10 organization, in which case -- and again, primary
11 care providers, in particular, would have to be
12 exclusive.

Page Range: 212:07-212:17

7 Q. Okay. Looking down to the last
8 paragraph here, it states about halfway through
9 it, "SAHS retains an open door for Saltzer at
10 present. Should Saltzer sell to St. Luke's,
11 that's another matter."
12 And again, we talked about before, do
13 you know whether that -- you don't know whether
14 they've been invited. Do you know whether that
15 door is still open for Saltzer physicians?
16 A. I don't think a formal decision has
17 been made on that.

Page Range: 214:14-214:25

14 Q. BY MR. SCHAFER: Dr. Brown,
15 Defendants' Exhibit 191 is a document Bates-
16 labeled BDC0009840 through 9862. The first page
17 is a Saint Alphonsus Health Alliance Board Meeting
18 agenda, and beyond that is a -- I'm assuming a
19 PowerPoint presentation called "Alliance Goals,
20 Objectives and Milestones," dated August 28, 2012.
21 Do you see that?
22 A. I see it.
23 Q. Did you play any part in putting
24 together this PowerPoint presentation?
25 A. Yes, I did.

Page Range: 222:13-223:16

13 Does Saint Alphonsus Health System
14 currently have contracts that involve -- that are
15 risk contracts?
16 A. No.
17 Q. Does the Alliance have any risk
18 contracts?
19 A. No.
20 Q. And if you look at Question 20, it asks
21 the question, "When will the Alliance enter into
22 risk contracts?" And it says, "Initially, the
23 Alliance will not enter into risk contracts but
24 will evolve with incentive contracts as the
25 informatics infrastructure and expertise develops
223:01 within the Alliance."
02 And then skipping to the end of that
03 next paragraph it says, "Eventually, the Alliance
04 will enter into well-considered full risk

05 contracts when systems are in place to manage
06 risk, but probably not before late 2014 or 2015."
07 Do you see that?
08 A. I do.
09 Q. And why -- why is it that the Alliance
10 was not going to enter into risk contracts until,
11 you know, the infrastructure or expertise was
12 better developed?
13 A. Because we would not have the
14 infrastructure expertise to measure a downside
15 risk and to educate the Alliance membership around
16 that.

Page Range: 225:03-225:16

03 Q. Okay. Since Saltzer's affiliation with
04 St. Luke's, has -- have you been informed of any
05 comments that payers have made regarding that
06 having an effect one way or another on their
07 contracting with the Alliance?
08 A. None. I have not heard any.
09 Q. Have you heard anything with respect to
10 either, you know, Saint Al's Health System or
11 Saint Al's Medical Group that providers
12 contracting, you know, those entities have said
13 that the affiliation of Saltzer and St. Luke's has
14 had an effect one way or another on that
15 contracting?
16 A. Not on contracting.

Page Range: 228:23-229:15

23 Q. Do you agree the traditional
24 fee-for-service model provides an incentive
25 for physicians and hospitals to overutilize
229:01 services?
02 A. That is what I have read.
03 Q. Do you agree with that?
04 A. I agree that there are aspects of that
05 to be true.
06 Q. Do you believe that financial
07 incentives can have an impact on the type of care
08 that physicians provide?
09 A. Yes.
10 Q. And the Alliance is planning on
11 including incentive structures in its contracts,
12 correct?
13 A. Correct.

- 14 Q. And it is for that reason?
15 A. It is to achieve the triple aim.

Page Range: 230:22-231:14

- 22 Q. You were also shown a document, it was
23 Defense Exhibit 190, in which you made a statement
24 that "I believe that Saltzer is in ACN."
25 Is -- is that accurate? Is Saltzer a
231:01 member of ACN?
02 A. Saltzer is a member of ACN. And,
03 hence, it has been folded into the Alliance.
04 Q. So does that mean that Saltzer is
05 currently a member of the Alliance?
06 A. Yes.
07 Q. To your knowledge, have there been any
08 discussions about removing Saltzer from the
09 Alliance?
10 A. No. I'm not aware of any discussions
11 around that. Of course, this raises concern that
12 Saltzer may decide not to be a member of the
13 Alliance, and that would create problems for a
14 network in our Nampa market.

Page Range: 232:07-232:09

- 07 Q. Has Saint Alphonsus identified any
08 alternative ways to obtain the same or similar
09 benefits of being an ACO?

Page Range: 232:12-232:21

- 12 A. The clinically integrated network
13 seeks to have the same outcomes as an accountable
14 care organization. But we'll be doing that
15 through partnership with employers, of course in
16 the internal employed and independent physicians,
17 hospitals and payers. That would also include
18 payers that have Advantage programs, so Medicare
19 Advantage programs.
20 So we can achieve essentially the same
21 kinds of results without being an ACO.

Page Range: 232:22-233:13

- 22 Q. Mr. Schafer asked you earlier if the
23 Idaho Health Data Exchange could be the sole
24 support for clinical integration. And you

25 responded, no, that it would also require a
233:01 patient registry method. Do you recall that?
02 A. I do.
03 Q. Do physicians need access to an EHR
04 system to have access to a patient registry?
05 A. No.
06 Q. And do they need an EHR system in order
07 to have a patient registry system interact with
08 the Idaho Health Data Exchange?
09 A. No, they don't. Recall that I said
10 that a great deal of what comes into a patient
11 registry is either through laboratory feeding
12 systems, electronic billing systems, and
13 adjudicated claims.